

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>00840</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>00822</p> </div> </div>																								
<p>1. PLACE OF DEATH</p> <p>a. COUNTY Kent MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown</p> <p>c. LENGTH OF STAY IN 1b 9 days</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital</p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE Maryland</p> <p>b. COUNTY Baltimore</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore</p> <p>d. STREET ADDRESS 1910 Branstone Road</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>																			
<p>3. NAME OF DECEASED (Type or print)</p> <p>First Anna Middle Grace Last Baker</p>			<p>4. DATE OF DEATH</p> <p>Month January Day 3 Year 19 66</p>		<p>5. SEX Female</p>			<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 1-24-1900</p>		<p>9. AGE (In years last birthday) 65 yrs.</p>		<p>10. IF UNDER 1 YEAR Months Days Hours Min.</p>		<p>11. IF UNDER 24 HRS.</p>						
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>					<p>10b. KIND OF BUSINESS OR INDUSTRY</p>					<p>11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland</p>					<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>									
<p>13. FATHER'S NAME George Brookheiser</p>					<p>14. MOTHER'S MAIDEN NAME Katherine Kelly</p>					<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No</p>					<p>16. SOCIAL SECURITY NO. Hospital Records</p>									
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) 410X Mitral and aortic valvulitis, severe</p> <p>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO advanced rheumatic heart disease</p> <p>DUE TO myocardial degeneration & pulm. edema</p>										<p>INTERVAL BETWEEN ONSET AND DEATH ?</p>														
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonitis, Adynamic ileus</p>										<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>														
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>					<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>																			
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. 19 p.m.</p>					<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>					<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>					<p>20f. (City or town) (County) (State)</p>									
<p>21. I certify that (I) (the hospital) attended the deceased from 12-25, 1965, to 1-3, 1966, that (I) (we) last saw the deceased alive on 1-3- 19 66, and that death occurred at 5:45 P.M. from the causes and on the date stated above.</p>																								
<p>22a. SIGNATURE Harry Paul Ross</p>										<p>22b. DATE SIGNED 1-4-66</p>					<p>22c. PHYSICIAN'S NAME (Type) Dr. Harry P. Ross</p>					<p>22d. ADDRESS Chestertown, Maryland</p>				
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>					<p>23b. DATE THEREOF 1-6-1966</p>					<p>23c. NAME OF CEMETERY OR CREMATORY Loudon Park</p>					<p>23d. LOCATION (City, town or county) (State) Baltimore, MD</p>									
<p>24. FUNERAL DIRECTOR F.C. Higginbotham</p>										<p>25a. REC'D BY REGISTRAR 10 1966</p>					<p>25b. REGISTRAR'S SIGNATURE Charles Judge</p>									

00088

00088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

00841

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00823

1. PLACE OF DEATH a. COUNTY Kent County Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Chestertown, Md. c. LENGTH OF STAY IN ID 45 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Chestertown, Maryland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Susie		First Susie Middle Brown Last Brown		4. DATE OF DEATH Month 1 Day 7 Year 1966			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/1894	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (County & State, or foreign country) Queen Anne's Co. Md.			
13. FATHER'S NAME Perry Wilson			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-24-2535		17. INFORMANT Thomas Brown			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency H16X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) no Rheumatic fever in childhood (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerosis Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 7-7- , 19 63 , to 1-3- , 19 66 , that (I) (we) last saw the deceased alive on 1-7- , 19 66 , and that death occurred at 10:34 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Rudolf Eglitis		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-8-66			
22c. PHYSICIAN'S NAME (Type) Rudolf Eglitis M.D.		22d. ADDRESS Rock Hall, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/11/1966		23c. NAME OF CEMETERY OR CREMATORY Pomona Cemetery			
23d. LOCATION (City, town or county) R.F.D. Chestertown, Md.		(State)					
24. FUNERAL DIRECTOR James W. Dicks		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR 12 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION

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VR A15 (4)
20M 1/65

00842

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00824

1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Worton</u> c. LENGTH OF STAY IN Id <u>11 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cath Comm</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Worton</u> <u>14-1</u> d. STREET ADDRESS <u>Cath Comm</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Clark</u> First <u>Bessie</u> Middle <u>Clark</u> Last <u>Clark</u>				4. DATE OF DEATH <u>Jan. 18 1966</u> Month <u>Jan.</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/6/81</u> yrs. <u>84</u>	
9. AGE (in years last birthday) <u>84</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home buying</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Liv oak Co. Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>James Monroe Grove</u>		14. MOTHER'S MAIDEN NAME <u>Nathum Holland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-38-1265</u>		17. INFORMANT <u>James 4. Clark</u>		Address <u>Worton, Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarct</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/18</u> , 19 <u>66</u> , to <u>1/18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/18</u> , 19 <u>66</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas J. Sokon</u>						22b. DATE SIGNED <u>1/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS J. SOKON</u>						22d. ADDRESS <u>Chesutown Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Jan. 21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chesutown Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Chesutown Kent Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Maurin C. Welham</u>				ADDRESS <u>Chesutown Ind.</u>		25a. REC'D BY REGISTRAR <u>JAN 24 1966</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

The first of the
 series of
 photographs
 showing the
 progress of the
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00843

00825

1. PLACE OF DEATH a. COUNTY Kent				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			
c. LENGTH OF STAY IN 1b 10 & 1/2 hrs.				d. STREET ADDRESS 201 Washington Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RICHARD		First PRICE		Middle GEORGE		Last GEORGE	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-3-06	
9. AGE (in years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk	
10b. KIND OF BUSINESS OR INDUSTRY D & R Supply Co.		11. BIRTHPLACE (County & State, or foreign country) Kent Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry L. George	
14. MOTHER'S MAIDEN NAME Sarah E. Cropper		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-6967		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 5277 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Pulmonary emphysema + pulmonary fibrosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Inactive pulmonary tuberculosis 0022							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1966 , to Jan. 15, 1966 , that (I) (we) last saw the deceased alive on Jan. 15, 1966 , and that death occurred at 10:50 PM , from the causes and on the date stated above.							
22a. SIGNATURE Dr. Robert W. Farr						22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Robert W. Farr						22d. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/18/66		23c. NAME OF CEMETERY OR CREMATORY Crumpton Cemetery		23d. LOCATION (City, town or county) (State) Crumpton, Md.	
24. FUNERAL DIRECTOR J. Willis Wells				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR JAN 20 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00844

00826

1. PLACE OF DEATH a. COUNTY Kent				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, RD #3 d. STREET ADDRESS XXXXX Violet Hill Farm			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY in lb 4 hours			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Beulah Eleanor Jones				4. DATE OF DEATH Month Day Year Jan. 11 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/24/1891	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days 74		IF UNDER 24 HRS. Hours Min. 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Kent Co., Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James E. Walbert				14. MOTHER'S MAIDEN NAME Elizabeth Larrimore			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 215-36-0289B			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/11/1966 to 1/11/1966 , that (I) (we) last saw the deceased alive on 1/11/1966 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE A. C. Dick				22b. DATE SIGNED 1-11-66		22c. ADDRESS Chestertown, Maryland	
22a. SIGNATURE Dr. A. C. Dick		22b. DATE SIGNED 1-11-66		22c. ADDRESS Chestertown, Maryland		22d. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/14/66		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town or county) (State) Chestertown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Marvin L. Williams				25a. REC'D BY REGISTRAR 17 JAN 17 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

UNBSE

0082

Warranted Agent

about

1-14-44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00845

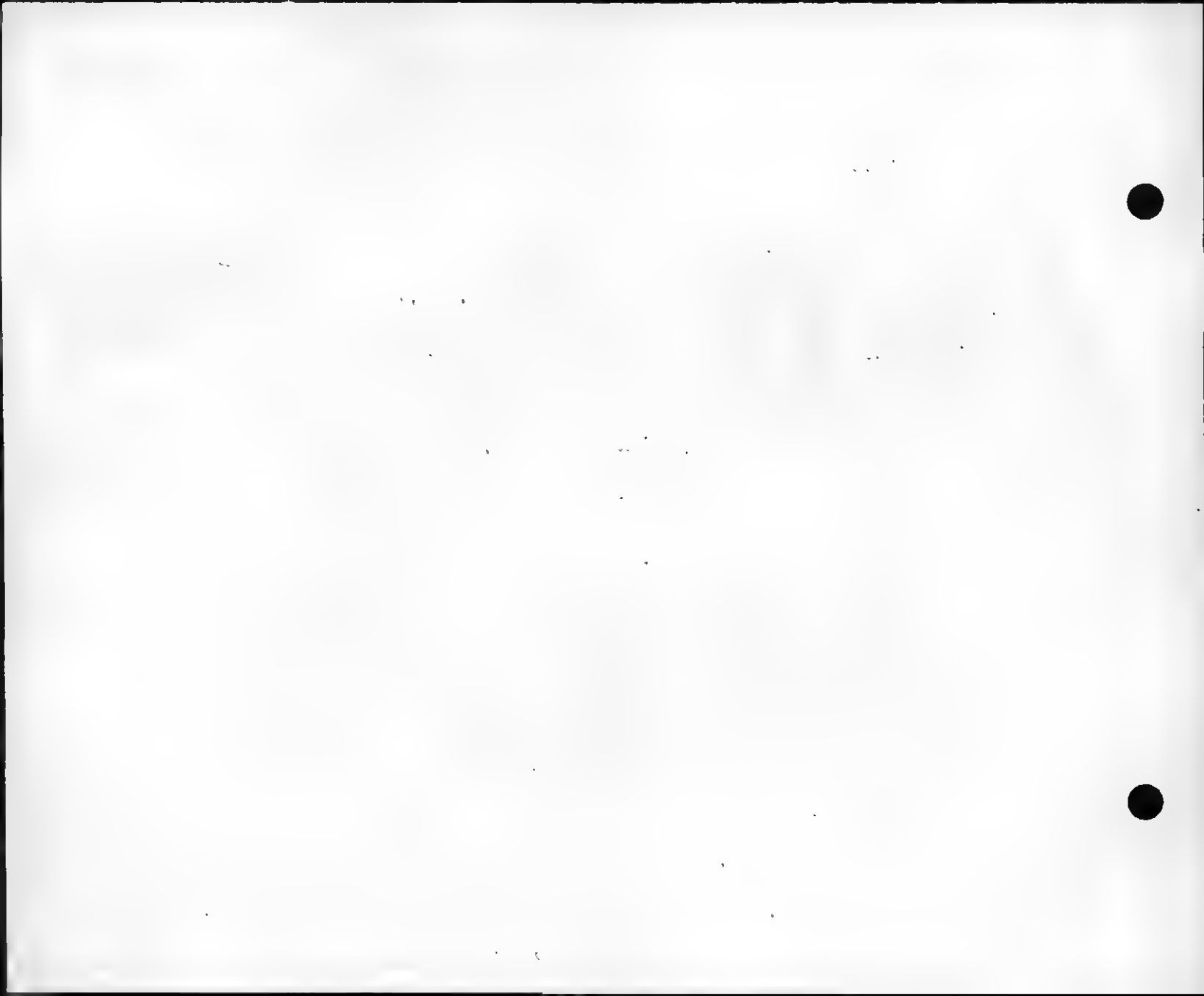
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00827

1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Tilden</u> Middle <u>Kelley</u> Last <u>Kelley</u>				4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 20, 1908</u>	
9. AGE (in years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>14</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat Yard Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles Kelley</u>				14. MOTHER'S MAIDEN NAME <u>Grace Scott</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-18-6352</u>		17. INFORMANT Address <u>Mrs. Hazel Frantz--Baltimore, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension - Arterio Sclerosis</u> DUE TO (c) <u>myocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1, 1964</u> to <u>Jan 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 14, 1966</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Norbert C. Nitsch</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Norbert C. Nitsch</u>				22d. ADDRESS <u>Rock Hall, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 18</u>		23c. NAME OF GEMETERY OR CREMATORY <u>Wesley Chapel</u>		23d. LOCATION (City, town or county) (State) <u>Rock Hall, Maryland</u>	
24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill, Maryland</u>		25a. REC'D BY REGISTRAR <u>26 1956</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be removed from the pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00846

00828

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chester town c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent + Queen Anne's				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Edison Kendall			4. DATE OF DEATH Month Day Year 1 24 1966				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-03	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Mln. 62		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Kent Co. Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Howard F. Kendall (214 16 4836)				
14. MOTHER'S MAIDEN NAME Mary E. Apsley			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				
16. SOCIAL SECURITY NO. 21416 4886			17. INFORMANT Ivy Kendall				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct DUE TO From family history long term heart disease Cardiac failure DUE TO Approximately 1 year ago + hospital stay + surgery Heart attack DUE TO Heart attack PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Minutes			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 2:00 A.M. , 19 66 , to 2:24 P.M. , 19 66 , that (I) (we) last saw the deceased alive on 1/27/66 , and that death occurred at 2:24 P.M. from the causes and on the date stated above.					
22a. SIGNATURE A.K. Dick		22b. DATE SIGNED 1-24-66		22c. PHYSICIAN'S NAME (Type) A.K. Dick			
22d. ADDRESS Chester town, Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF 1/27/66		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem		23d. LOCATION (City, town or county) (State) Rock Hall, Md.			
24. FUNERAL DIRECTOR J. Willis Wells		25a. REC'D BY REGISTRAR JAN 26 1966		25b. REGISTRAR'S SIGNATURE Charles J. George			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

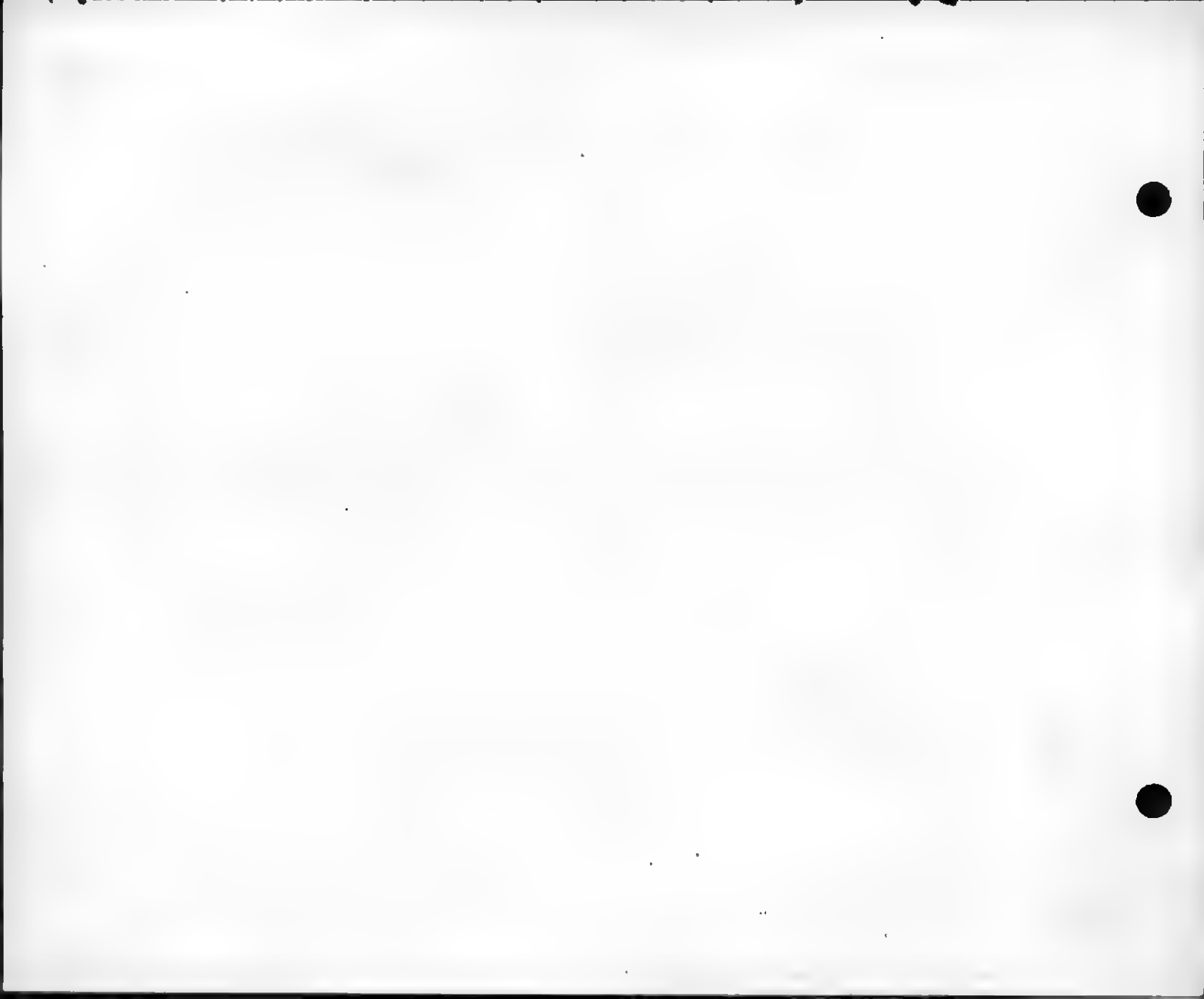
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00847

CERTIFICATE OF DEATH

00829

1 PLACE OF DEATH a. COUNTY Kent MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission a. STATE MD. b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYDEL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent + Queen Anne's		d. STREET ADDRESS 1-1	
3 NAME OF DECEASED (Type or print) First Middle Last Florence Eva Moore		4 DATE OF DEATH Month Day Year January 31 1966	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-25-1911
9 AGE (In years last birthday) 54 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY At Home		11 BIRTHPLACE (County & State, or foreign country) DELAWARE	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME JOHN COCHRAN	
14 MOTHER'S MAIDEN NAME SARAH ELLEN ASHEY		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO 222-14-5936		17 INFORMANT Hospital Records Address Chestertown Md.	
18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of liver 1562 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholelithiasis - cholecystitis		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-8 , 1966, to 1-31 , 1966, that (I) (we) last saw the deceased alive on 1-31 , 1966, and that death occurred on 2-2 P.M., from causes and on the date stated above.			
22a. SIGNATURE A.C. Dick M.D.		22b. DATE SIGNED 1-31-66	
22c. PHYSICIAN'S NAME (Type) A.C. Dick		22d. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2-4-66	23c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS CEMETERY	23d. LOCATION (City or Town) (County) (State) SMYRNA KENT DEL.
24. FUNERAL DIRECTOR Charles Wells Chestertown, Md.		25a. REC'D BY REGISTRAR FEB 4 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00848

00830

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 25 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Anne's Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kennedyville d. STREET ADDRESS Kennedyville e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle ALBERT Last NICKERSON			4. DATE OF DEATH Month January Day 3 Year 19 66				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1880	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE		11. BIRTHPLACE (County & State, or foreign country) Kent Co., Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Samuel Nickerson				
14. MOTHER'S MAIDEN NAME Martha Lister			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				
16. SOCIAL SECURITY NO. 218-10-0687			17. INFORMANT Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke & Rt Hemiplegia DUE TO Arteriosclerotic cardiovascular disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) years - (c) 1 month					INTERVAL BETWEEN ONSET AND DEATH 1 month		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chestertown, Maryland			
21. I certify that (I) (this hospital) attended the deceased from Dec. 9, 1965 , to Jan. 3, 1966 , that (I) (we) last saw the deceased alive on 1-2, 1966 , and that death occurred at 12:05 AM , from the causes and on the date stated above.							
22a. SIGNATURE Harry P. Ross				22b. DATE SIGNED 1-3-66			
22c. PHYSICIAN'S NAME (Type) Dr. Harry P. Ross				22d. ADDRESS Chestertown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-5-66		23c. NAME OF CEMETERY OR CREMATORY CHESTER CEMT			
23d. LOCATION (City, town or county) CHESTERTOWN, MD		23e. LOCATION (City, town or county) CHESTERTOWN, MD		23f. LOCATION (City, town or county) CHESTERTOWN, MD			
24. FUNERAL DIRECTOR Walter N. Kennedy				25a. REC'D BY REGISTRAR STILLFOND, MD.			
25b. REGISTRAR'S SIGNATURE Walter N. Kennedy				25c. DATE JAN 5 1966			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

00849

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00831

1. PLACE OF DEATH a. COUNTY Kent County, Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Maryland c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Maryland d. STREET ADDRESS 117 Railroad Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leonard Robinson		4. DATE OF DEATH 1 11 19 66	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/19/1900
9. AGE (in years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Various	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Robinson		14. MOTHER'S MAIDEN NAME Harriett Burgess	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. Hollis Robinson		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular disease DUE TO He had been working the day before. Was found dead about 1 A.M. Associates said (b) that he complained of indigestion the P.M. before. Manner of death resembled coronary thrombosis. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr M. D.		22. DATE SIGNED 1-13-66	
EXAMINER'S NAME (Type) Robert W. Farr M. D.		Address (Street, city, town, or county) Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/15/1966	
23c. NAME OF CEMETERY OR CREMATORY Janes Cemetery		23d. LOCATION (City, town or county) (State) Chestertown, Maryland	
24. FUNERAL DIRECTOR Samuel W. W. W.		25a. REC'D BY REGISTRAR 17 1956	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE J. W. W. W.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00850

CERTIFICATE OF DEATH

00832

1. PLACE OF DEATH a. COUNTY Kent County, Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D.#1 Worton, Md.		c. LENGTH OF STAY IN ID Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D.#1 Worton, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home				d. STREET ADDRESS 14-1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eva		First Eva Middle Simmons Last Simmons		4. DATE OF DEATH Month 1 Day 17 Year 1966			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/21/1887	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.	IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (County & State, or foreign country) Kent County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Wilson				14. MOTHER'S MAIDEN NAME Annie Naylor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Elwood Wilson		Address R.F.D.#1 Worton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 442X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cardiovascular Nephrosis (b) Cardiovascular Nephrosis (c) Cardiovascular Nephrosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 18, 1955 to Jan 17, 1966 , that (I) (we) last saw the deceased alive on Jan 16, 1966 , and that death occurred at 2:4 M. from the causes and on the date stated above.							
22a. SIGNATURE Norbert C. Nitsch				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Norbert C. Nitsch M.D.				22d. ADDRESS Rock Hall, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/22/1966		23c. NAME OF CEMETERY OR CREMATORY Fountain Cemetery		23d. LOCATION (City, town or county) (State) Near Lynch, Maryland	
24. FUNERAL DIRECTOR Samuel W. Wally		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATA 21 1966		25b. REGISTRAR'S SIGNATURE William J. Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					00833				
1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN MD Lifetime d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 123 E. High St					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS 123 East High e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Norman D. Sutton					4. DATE OF DEATH Jan. 30, 1966 19				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/29/1911		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery store clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR: Months Days Hours Min.	
13. FATHER'S NAME J. Bayard Sutton					14. MOTHER'S MAIDEN NAME Myrtle Durdin				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) np		16. SOCIAL SECURITY NO. 224 05 1756		17. INFORMANT Norman Sutton Address Chestertown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Arterio-sclerotic cardiovascular disease IMMEDIATE CAUSE (a) (Resembled acute attack of coronary thrombosis) 4201 DUE TO Had been shoveling snow all day. Fell dead in bathroom 7:30 P.M. (b) DUE TO (c) CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Robert W. Farr		EXAMINER'S NAME (Type) Robert W. Farr, M. D.		22. DATE SIGNED 2/3/66		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/4/66		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town or county) (State) Chestertown, Md.			
24. FUNERAL DIRECTOR J. Wells Wells		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			

